



Return Patient Visit Form

- A. Reason for your visit today:**
 Medication refill
 Follow up after a procedure
 Routine follow-up
 Other, please explain _____

<i>Office Use Only</i>	
Blood Pressure:	_____
Heart Rate:	_____
Temperature:	_____
Weight:	_____

B. Has your pain changed since the last visit: Yes No

C. Nature of Pain: Constant Intermittent

Intensity of Pain: On a scale of 0-10, with 10 being the worst imaginable pain and 0 the absence of pain; how would you rate your pain?

At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
Average:	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse?

- Bending Lifting Coughing Sneezing Defecation
 Prolonged Sitting Prolonged Standing Walking
 Other, please explain _____

What makes your pain better?

- Rest Activity/physical therapy Massage Heat Cold
 Lying in a fetal position Lying on your back Medication
 Other, please explain _____

D. Have you had any new medical problems or hospitalizations since your last clinic visit?

- Yes No
 If yes, please explain: _____

E. Have you started any new medication(s) not prescribed by my office since the last clinic visit?

- Yes No
 If yes, please list the name(s) and dose(s) of the medication(s):

F. Have you noticed any side effects from medications: Yes No

If yes, please explain: _____

